

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **28447**

WED AUG 22 1941
Registration District No. **328**

Primary Registration District No. **4232**

Registrar's No. **38**

1. PLACE OF DEATH:

(a) County **Howard**
(b) City or town **Fayette**
(c) Name of hospital or institution: **None**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **None** (Specify whether)
In this community **0** years, months or days

3. (a) PRINT FULL NAME **Robert Allen Sanders**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. **Male** 5. Color or race **Black** 6. (a) Single, widowed, married, divorced **1**

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **April 28th 1941**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
2 **7** hr. min.

9. Birthplace **Indiana** (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name **Robert Sanders**
13. Birthplace **Indiana** (City, town, or county) (State or foreign country)
14. Maiden name **Lagora Tevenbaugh**
15. Birthplace **Missouri** (City, town, or county) (State or foreign country)

16. (a) Informant **J. A. Tevenbaugh**
(b) Address **Fayette, Mo.**

17. (a) **Burial** (b) Date thereof **7-8th 1941**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Gary, Indiana**
Guy T. Halley

18. (a) Signature of funeral director _____
(b) Address **Fayette, Mo.**

19. (a) **7-6-41** (b) **Anna P. Tindall**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Indiana** (b) County **Howard**
(c) City or town **Gary** (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. **2** years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **5th** day **July**
year **1941** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from **7-5-41**
that I last saw him alive on **7-5**
and that death occurred on the date and hour stated above.

Immediate cause of death **fracture of**
skull

Due to **Struck by car**

Due to **Trauma**

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **Accident**

(b) Date of occurrence **6-5-41** **043**

(c) Where did injury occur? **Fayette Mo - Howard Mo**

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? **no** (Specify type of place)

(e) Means of injury **Auto wreck**

23. Signature **W. J. [illegible]** (M. D. or other) **4.2**

Address **Fayette Mo** Date signed **7-6-41**

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 8-27-41

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by

, Registered Apprentice No.

working under my personal supervision.

Signed

Licensed Embalmer No. 21766

P. O. Address Langille Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.